

NEW YORK STATE DEPARTMENT OF HEALTH

PERMIT APPLICATION / PERMANENT INFORMATION RECORD

FOR MOBILE HOME PARKS

SECTION I - TO BE COMPLETED BY LOCAL HEALTH UNIT

Co.	Fac. Code	A		Type of Permit	Per Eff. Date	Per Exp. Date
(1) <input type="checkbox"/> 0	(2) <input type="checkbox"/> 3	(3) <input type="checkbox"/>		(1) <input type="checkbox"/> Permanent (2) <input type="checkbox"/> Temporary (3) <input type="checkbox"/> Other	Mo. Day Yr.	Mo. Day Yr.
(1)			(10)		(11)	

Water System	Sewage System
(1) <input type="checkbox"/> Municipal (2) <input type="checkbox"/> Private If Private: # of Sources <input style="width: 20px;" type="text"/>	(1) <input type="checkbox"/> Chlorinated (2) <input type="checkbox"/> Unchlorinated (1) <input type="checkbox"/> Public (2) <input type="checkbox"/> Private If Private: (1) <input type="checkbox"/> Community (2) <input type="checkbox"/> Cluster (3) <input type="checkbox"/> Individual Site
(23)	(28)

SECTION II - TO BE COMPLETED BY ALL OPERATORS. COMPLETE ONLY NEW OR REVISED DATA AND SIGN ON BACK. INSTRUCTIONS FOR THE COMPLETION OF THIS FORM ARE ON THE BACK OF THIS SHEET. COMPLETE IN PEN (DO NOT USE BLUE INK).

Facility Name <input style="width: 800px;" type="text"/>	
Town, Village or City <input style="width: 300px;" type="text"/>	T.V. or C <input style="width: 20px;" type="checkbox"/>
County <input style="width: 250px;" type="text"/>	Today's Date <input style="width: 50px;" type="text"/> Mo. <input style="width: 50px;" type="text"/> Day <input style="width: 50px;" type="text"/> Yr. <input style="width: 50px;" type="text"/>
Name of Legal Operator or Operating Corp. (Sign on back) <input style="width: 550px;" type="text"/>	Area Code <input style="width: 40px;" type="text"/> Telephone <input style="width: 100px;" type="text"/>
Employer Identification Number or Social Security Number <input style="width: 150px;" type="text"/>	Capacity (# of Sites) <input style="width: 40px;" type="text"/>
EIN <input style="width: 40px;" type="text"/> SSN <input style="width: 40px;" type="text"/>	Occupied (# of Sites) <input style="width: 40px;" type="text"/>
If Corp., Name of Person in Charge <input style="width: 550px;" type="text"/>	Type of Application (1) <input type="checkbox"/> Renewal (2) <input type="checkbox"/> New MHP (3) <input type="checkbox"/> New Owner/Operator
Address of Operator (Street) <input style="width: 550px;" type="text"/>	Area Code <input style="width: 40px;" type="text"/> Telephone <input style="width: 100px;" type="text"/>
City or Village <input style="width: 300px;" type="text"/>	State <input style="width: 40px;" type="text"/> Zip Code <input style="width: 60px;" type="text"/>
Name of Owner (If other than Operator) <input style="width: 550px;" type="text"/>	Additional Facilities:
Permanent Address of Owner (Street) <input style="width: 550px;" type="text"/>	(279) Outdoor Pool(s) <input style="width: 40px;" type="text"/> (281) Indoor Pool(s) <input style="width: 40px;" type="text"/> (283) Bathing Beach(es) <input style="width: 40px;" type="text"/> (285) Whirlpool(s) <input style="width: 40px;" type="text"/> (287) Food Service(s) <input style="width: 40px;" type="text"/> (289) Temporary Residence(s) <input style="width: 40px;" type="text"/>
City or Village <input style="width: 300px;" type="text"/>	Number:
State <input style="width: 40px;" type="text"/> Zip Code <input style="width: 60px;" type="text"/>	

INSTRUCTIONS:

SECTION II - Fill in only one letter or number per box, beginning with the first box in each item. Leave one blank space between words, do not use punctuation and use abbreviations as necessary. If data appears below the empty boxes (numbered items) in Section II, fill in only those items which have incorrect or incomplete preprinted data below them, or which need updating. Do not complete items which have correct preprinted data below them. Do not fill out Sections I or IV. Section III must be signed by the operator. Forms not completely or legibly filled out will be returned to the operator and will delay issuance of the operating permit. For more detailed instructions, consult with the Health Department Office which issues your operating permit.

SECTION III-TO BE COMPLETED BY ALL OPERATORS

Detailed Location

Copy of Part 17 of State Sanitary Code received: ☐ Yes ☐ No

If new owner or operator :

Former facility name :

Former operator's name :

This is to Certify, Under the Penalties of Perjury, that the above described operation has workers' compensation and disability benefits coverage required by law:

Workers' Compensation Carrier

W.C. Policy No.

Expiration Date

Disability Benefits Carrier

D.B. Policy No.

Expiration Date

OR THAT THE WORKERS' COMPENSATION BOARD HAS ISSUED FORM C-105.21
Stating that such coverage is not required.

Dated _____

I hereby agree to allow the representatives of the Permit Issuing Official to enter upon my property during daylight hours to conduct inspections as to compliance with Part 17 of the State Sanitary Code.

I CERTIFY THAT THE INFORMATION GIVEN IN THIS APPLICATION IS TRUE:

SIGNATURE OF INDIVIDUAL OPERATOR OR OF
OFFICIAL OPERATING PERSON

Print Name of Person Signing

Title

If not an individual operator, give official connection with the operating "person"

FALSE STATEMENTS MADE ON THIS APPLICATION ARE PUNISHABLE UNDER THE PENAL LAW**SECTION IV - TO BE COMPLETED BY LOCAL HEALTH UNIT**

Required Plans Submitted

Date

Approved by:

Name

Date

☐ Yes ☐ No

Issuance Recommended By:

Name

Title

Field Office

Expiration Date